Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

December 2019

In this issue

Hospital outpatient prospective payment (OPPS) and ambulatory surgical center (ASC) payment systems and quality reporting

The American Hospital Association (AMA) challenged the Centers for Medicare & Medicaid Services' (CMS) use of its authority under Subsection (t)(2)(F) of the Medicare statute to pay for certain outpatient clinic visit services provided at excepted off-campus provider-based departments (PBDs) at the same rate that CMS uses to pay non-excepted off-campus PBDs for those services under the separate Physician Fee Schedule as finalized with final Rule, Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting, 83 Fed. Reg. 58,818 (Nov. 21, 2018) (Rule).

The United States District Court for the District of Columbia issued instructions for CMS to immediately cease paying the reduced amount for clinic visits furnished at excepted off-campus PBDs for CY 2019 implemented in the Rule.

CMS installed a revised Hospital OPPS Pricer to update the rates being applied to claim lines. The revised Pricer went into production on November 4, 2019, and applies to claims with a line item date of service of January 1, 2019, and after. Starting January 1, 2020, and over the next few months, the Medicare administrative contractors will automatically reprocess 2019 claims paid at the reduced rate; no provider action needed.

In the 2020 OPPS final rule, CMS is completing the two-year phase-in to apply the full amount of the reduction in payment for clinic visits furnished in off-campus provider-based departments to the same amount paid under the PFS. This policy was adopted as a method to control unnecessary increases in the volume of clinic visit services furnished in off-campus provider-based departments paid under the OPPS and will help reduce out-of-pocket costs for Medicare beneficiaries. From the final 2020 OPPS rule: "We acknowledge that the district court vacated the volume control policy for CY 2019 and we are working to ensure affected 2019 claims for clinic visits are paid consistent with the court's order. We do not believe it is appropriate at this time to make a change to the second year of the two-year phase-in of the clinic visit policy." (84 FR 61145) In the final rule, CMS stated that the government was evaluating its appeal rights and considering whether to appeal from the court's final judgment. On December 12, 2019, the Department filed its notices of appeal in the three consolidated cases in the United States District Court for the District of Columbia Circuit.

Contents

The *Medicare A Connection* is published monthly by First Coast Service Options Inc.'s Provider Outreach & Education division to provide timely and useful information to Medicare Part A providers.

Articles included in the *Medicare A Connection* represent formal notice of coverage policies. Policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with Medicare coverage and payment guidelines.

Billing

2020 Annual Update of Per-Beneficiary Threshold Amounts

Provider type affected

This MLN Matters Article is intended for physicians, therapists, and other providers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

Provider action needed

CR 11532 updates the annual per-beneficiary incurred expenses amounts now called the KX modifier thresholds and related policy for CY 2020. These amounts were previously associated with the financial limitation amounts that were more commonly referred to as "therapy caps" before the Bipartisan Budget Act of 2018 was signed into law repealing the application of the caps.

For CY 2020, the KX modifier threshold amounts are: (a) $2,080 for Physical Therapy (PT) and Speech-Language Pathology (SLP) services combined, and (b) $2,080 for Occupational Therapy (OT) services. Make sure your billing staffs are aware of these updates.

Background

Section 50202 of the Bipartisan Budget Act of 2018, P.L. 115-123 (BBA of 2018) amended Section 1833(g) of the Social Security Act (the Act) to repeal the application of the therapy caps while also retaining and adding limitations to ensure appropriate therapy.

A provision of Section 50202 of the BBA of 2018 adds Section 1833(g)(7)(A) of the Act to preserve the former therapy cap amounts as thresholds above which claims must include the KX modifier to confirm that services are medically necessary as justified by appropriate documentation in the medical record. These amounts are now known as the KX modifier thresholds; and, there is one amount for PT and SLP services combined and a separate amount for OT services. Medicare will deny your claims for therapy services above these amounts without the KX modifier.

These per-beneficiary amounts under Section 1833(g) of the Act (as amended by 1997 BBA are updated each year by the Medicare Economic Index (MEI). For CY 2020, the KX modifier threshold amounts are: (a) $2,080 for PT and SLP services combined, and (b) $2,080 for OT services.

Another provision of Section 50202 of the BBA of 2018 adds Section 1833(g)(7)(B) of the Act to maintain the targeted medical review process (first established through Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015) but at a lower threshold amount of $3,000. This threshold amount is now termed the Medical Record (MR) threshold amount – one MR threshold amount for PT and SLP services combined and another for OT services – remains at $3,000 until CY 2028 at which time it will be updated by the MEI.

Additional information

The official instruction, CR 11532, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4419CP.pdf*.

If you have questions, your MACs may have more information. Find their website at *http://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
November 12, 2019	Initial article released.

MLN Matters® Number: MM11532
Related CR Release Date: October 25, 2019
Related CR Transmittal Number: R4419CP
Related Change Request (CR) Number: 11532
Effective Date: January 1, 2020
Implementation Date: January 6, 2020

Where do I find...

Looking for something specific and don't know where to find it? Find out how to perform routine tasks or locate information that visitors frequently visit our site to accomplish or find. Check out the "Where do I find" page.

Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2020

Provider type affected

This MLN Matters Article is for physicians, providers and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice MACs and Durable Medical Equipment (DME MACs) for services provided to Medicare beneficiaries.

Provider action needed

CR 11542 instructs the MACs to update the claims processing system with the new Calendar Year (CY) 2020 Medicare rates. These updates relate to Chapter 3, sections 10.3, 20.2, and 20.6 of the Medicare General Information, Eligibility, and Entitlement Manual, which are attachments to the CR. Please make sure your billing staffs are aware of these changes.

Background

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. Beneficiaries are responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When beneficiaries receive such services for more than 60 days during a spell of illness, they are responsible for a coinsurance amount equal to one-fourth (25 percent) of the inpatient hospital deductible per day for the 61st through 90th days in the hospital. A beneficiary has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness.

Most individuals aged 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act (the Act) provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 10-percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10-percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

The 2020 Part A and B deductible, coinsurance, and premium rates are as follows:

2020 Part A – Hospital Insurance (HI)

- **Part A Deductible**
  - o $1,408.00
- **Part A Coinsurance**
  - o $352.00 a day for 61st-90th days
  - o $704.00 a day for 91st-150th days (lifetime reserve days)
  - o $176.00 a day for 21st-100th days (SNF coinsurance)
- **Part A Base Premium (BP)**
  - $458.00 a month
- **Part A BP with 10-Percent Surcharge**
  - o $503.80 a month
- **Part A BP with 45-Percent Reduction**
  - o $252.00 a month (for those who have 30-39 quarters of coverage)
- **Part A BP with 45-Percent Reduction and 10-Percent Surcharge**
  - o $277.20 a month

2020 Part B – Supplementary Medical Insurance (SMI)

Part B Standard Premium
- o $144.60 a month
- **Part B Deductible**
  - o $198.00 a year
- **Pro Rata Data Amount**
  - o $140.46 - 1st month
  - o $57.54 - 2nd month
- **Coinsurance**
  - o 20 percent

Note: See Attachment A of CR11542 for "Income Parameters for Determining Part B Premium"

Additional information

The official instruction, CR 11542, issued to your MAC regarding this change is available at *https://www.cms.gov/files/document/r129gi*.

If you have questions, your MACs may have more information. Find their website at *http://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
November 22, 2019	Initial article released.

MLN Matters® Number: MM11542
Related CR Release Date: November 22, 2019
Related CR Transmittal Number: R129GI
Related Change Request (CR) Number: 11542
Effective Date: January 1, 2020
Implementation Date: January 6, 2020

This section of *Medicare A Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction N (JN) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our *LCDs/Medical Coverage webpage* for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the *First Coast eNews mailing list*. Simply enter your email address and select the subscription option that best meets your needs.

More information

For more information, or, if you do not have internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? *First Coast's LCD lookup* helps you find the coverage information you need quickly and easily. Just enter a procedure code, keyword, or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your internet connection, the LCD search process can be completed in less than 10 seconds.

Advance beneficiary notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

Find fees faster: Try First Coast's fee schedule lookup

Find the fee schedule information you need fast - with ***First Coast's fee schedule lookup***. This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

Additional Information

National noncovered services -- revision to the Part A and Part B Billing and Coding Article

Article ID number: A57742 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on the 2020 Healthcare Common Procedure Coding System (HCPCS) Update, the national noncovered services billing and coding article was revised to add Current Procedural Terminology (CPT®) codes 0567T and 0568T to the "Article Text:" section under "Part B Only". In addition, CPT® code 58565 was added under the "Part A and Part B:" section of this billing and coding article (not related to the 2020 HCPCS Update).

Effective date

This Billing and Coding Article revision is effective for services rendered **on or after January 1, 2020.**

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. A billing and coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

2020 HCPCS Part A/B, Part A and Part B billing and coding article changes

First Coast Service Options Inc. has revised local coverage determination (LCD) billing and coding articles impacted by the 2020 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted. The following is a list of the impacted LCD billing and coding articles.

Part A/B Combined LCD Billing and Coding Articles

L33615/A57635 Biofeedback

L36209/A57076 Cardiology – non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET

L34043/A57675 Dysphagia/Swallowing Diagnosis and Therapy

L36276/A57628 Erythropoiesis Stimulating Agents

L34519/A57451 Molecular Pathology Procedures

L33777/A57743 Noncovered Services

L34017/A57470 Ophthalmoscopy

L33707/A57127 Pulmonary Diagnostic Services

L34521/A57667 Special EEG Tests

L33413/A57156 Therapy and Rehabilitation Services

Part B only LCD Billing and Coding Articles

L33815/A57082 Diagnostic Nasal Endoscopy

L33834/A57754 Health and Behavior Assessment/ Intervention

L33910/A57807 Independent Diagnostic Testing Facility (IDTF)

L33933/A57788 Peripheral Nerve Blocks

Effective date

These LCD billing and coding article revisions are effective for services rendered **on or after January 1, 2020.**

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Noncovered services -- revision to the Part A and Part B Billing and Coding Article

Article ID number: A57743 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on development of a new local coverage determination (LCD) for micro-invasive glaucoma surgery (MIGS), the noncovered services billing and coding article was revised to remove Current Procedural Terminology (CPT®) codes 0253T and 0450T from the "CPT®/HCPCS Codes/Group 1 Codes:" section and place them in the related billing and coding article for the new MIGS LCD under the "Group 3 Codes:" (CPT codes that are considered not medically and reasonable and necessary [non-covered]) section.

Effective date

This Billing and Coding Article revision is effective for services rendered **on or after December 30, 2019.**

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Bone mineral density studies -- revision to the Part A and Part B Billing and Coding Article

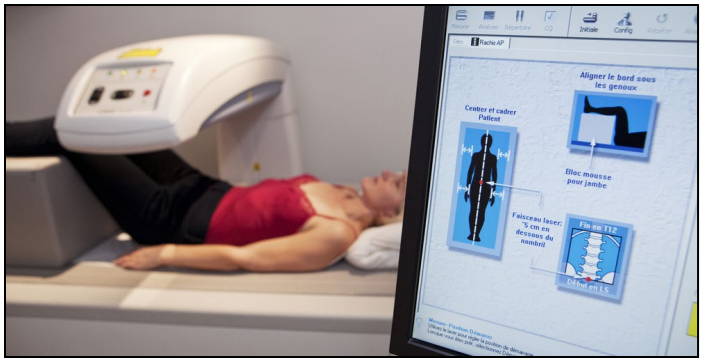
Article ID number: A56484 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 11392 (ICD-10 and Other Coding Revisions to National Coverage Determinations [NCDs] - January 2020 Update), the billing and coding article was revised to remove ICD-10-CM diagnosis codes M85.9, M89.9, M94.9, and Q55.4 for Current Procedural Terminology (CPT®) codes 77080, 77085, and 0508T and ICD-10-CM diagnosis codes M85.9 and Q55.4 for CPT®/HCPCS codes 0554T, 0555T, 0556T, 0557T, 0558T, 76977, 77078, 77081, and G0130.

Effective date

This Billing and Coding Article revision is effective for services rendered **on or after January 1, 2020.**

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.



A billing and coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Medicare A Connection subscription

Medicare A Connection is published monthly and is available online in both English and Spanish.

Non-provider entities or providers who need additional copies may purchase an annual hardcopy subscription. This subscription includes all issues published in the current fiscal year.

To order an annual subscription, complete the *Medicare A Connection Subscription Form, **located here***.

Upcoming provider outreach and educational events

Medicare quarterly updates

Date: March 17, 2020
Time: 10-11:30 a.m. ET
Type of Event: Webcast

View our complete calendar of events

Note: Unless otherwise indicated, designated times for educational events are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands.

Two easy ways to register

Online – Visit our provider training website at *First Coast University*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**.**

First-time User? Set up an account by completing *Create User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our *website* for details and newly scheduled educational events (teleconferences, webcasts, etc.).

Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the First Coast Medicare training website, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the First Coast Medicare training website and explore our catalog of online courses.

CMS MLN Connects®

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects*® is an official *Medicare Learning Network*® (*MLN*) – branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the *MLN Connects*® to its membership as appropriate.

MLN Connects® – Special Edition for November 19, 2019

New Medicare Card: Get Paid January 1, 2020 – Use MBIs Now

Do not wait. Update your patients' records and use Medicare Beneficiary identifiers (MBIs) now, before you are busy with other patient insurance changes in January.

We encourage people with Medicare to carry their cards with them since we removed the Social Security Number-based number; if your patients do not bring their Medicare cards with them:

- Give them the Get Your New Medicare Card flyer in *English* (or *Spanish*)
- Use your Medicare Administrative Contractor's look-up tool. *Sign up* for the Portal to use the tool
- Check the remittance advice. Until December 2019, we return the MBI on the remittance advice for every claim with a valid and active Health Insurance Claim Number (HICN)

Starting January 1, you must use MBIs to bill Medicare regardless of the date of service:

- We will reject claims submitted with HICNs with a few *exceptions*
- We will reject all eligibility transactions submitted with HICNs

See the *MLN Matters Article* for answers to your questions on using MBIs.

Medicare Learning Network®

The *Medicare Learning Network*® (*MLN*) is the home for education, information, and resources for the health care professional community. The *MLN* provides access to CMS Program information you need, when you need it, so you can focus more on providing care to your patients. Find out what the *MLN* has to offer you and your staff at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html*.

MLN Connects® for Thursday, November 21, 2019

MLN Connects® for Thursday, November 21, 2019

View this edition as a PDF

News

- Promoting Interoperability Programs: Updated list of eCQMs
- MIPS Improvement Activities Technical Expert Panel: Nominations due November 29
- DMEPOS Competitive Bidding Surveys: Comment by December 20
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- Modernizing CMS: Organizational Changes Announced

Compliance

- Improper Payment for Intensity-Modulated Radiation Therapy Planning Services

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- Hospital Price Transparency Final Rule Call — December 3
- Hospice Quality Reporting Program Forum Webinar — December 4
- Ground Ambulance Organizations: Data Collection System Call — December 5

MLN Matters® Articles

- 2020 Annual Update to the Therapy Code List
- 2020 Annual Update of Per-Beneficiary Threshold Amounts
- Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020
- Home Health (HH) Patient-Driven Groupings Model (PDGM) - Revised and Additional Manual Instructions
- Medicare Physician Fee Schedule Database (MPFSDB) Update to Status Indicators
- Positron Emission Tomography (PET) Scan - Allow Tracer Codes Q9982 and Q9983 in the Fiscal Intermediary Shared System (FISS)
- Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2020

Publications

- Medical Privacy of Protected Health Information — Revised
- Remittance Advice Resources and FAQs — Revised

Multimedia

- Part A Cost Report Webcast: Audio Recording and Transcript
- Improving Health Care Quality for LGBTQ People Web-Based Training Course — Updated

MLN Connects® – Special Edition for November 26, 2019

New Medicare Card: Claim Reject Codes After January 1

Get paid. Use Medicare Beneficiary Identifiers (MBIs) now.

If you do not use MBIs on claims (with a few *exceptions*) after January 1, you will get:

- Electronic claims reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber)
- Paper claims notices: Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/ invalid patient identifier"

We encourage people with Medicare to carry their cards with them since we removed the Social Security Number-based number; if your patients do not bring their Medicare cards with them:

- Give them the Get Your New Medicare Card flyer in *English* (or *Spanish*)
- Use your Medicare Administrative Contractor's look-up tool. *Sign up* for the Portal to use the tool
- Check the remittance advice. Until December 2019, we return the MBI on the remittance advice for every claim with a valid and active Health Insurance Claim Number (HICN)

See the *MLN Matters Article* to learn how to get and use MBIs.

MLN Connects® for Wednesday, November 27, 2019

MLN Connects® for Thursday, November 27, 2019

View this edition as a PDF

News

- FY 2019 Medicare FFS Improper Payment Rate Lowest Since 2010
- Patients Over Paperwork Newsletter
- Celebration of National Rural Health Day
- November is Home Care and Hospice Month
- World AIDS Day is December 1

Compliance

- Ambulance Fee Schedule and Medicare Transports

Events

- Hospital Price Transparency Final Rule Call — December 3
- Ground Ambulance Organizations: Data Collection System Call — December 5

MLN Matters® Articles

- Home Health Agencies (HHAs) Urged to Establish Access to the Internet Quality Improvement and Evaluation System (iQIES) By December 23, 2019
- Claim Status Category and Claim Status Codes Update
- Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2020
- Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2020
- Updating Fiscal Intermediary Shared System (FISS) Editing for Practice Locations to Bypass Mobile Facility and/or Portable Units and Services Rendered in the Patient's Home
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2020 — Revised

Publications

- Quality Payment Program: MIPS and APM Resources
- ACOs: Beneficiary Engagement Toolkit and Case Studies

Multimedia

- Physician Fee Schedule and Hospital OPPS/ASC Call: Audio Recording and Transcript

MLN Connects® – Special Edition for December 3, 2019

MBI Transition Ends This Month: Will You Be Paid on January 1?

The 21 month transition period will end on December 31; use Medicare Beneficiary identifiers (MBIs) now.

- You are currently submitting 86% of claims with MBIs
- Get MBIs from your patients and through the MAC portals (*sign up*) now and after the transition period. You can also find the MBI on the remittance advice
- Protect your patients from identity theft - use MBIs

Starting January 1, if you do not use the MBI (regardless of the date of service) for Medicare transactions

- We will reject claims submitted with HICNs with a few *exceptions*
- We will reject all eligibility transactions

See the *MLN Matters Article* for more information on getting and using MBIs.

MLN Connects® for Wednesday, December 5, 2019

MLN Connects® for Thursday, December 5, 2019

View this edition as a PDF

News

- Direct Contracting Risk-Sharing Options: Submit Letter of Intent by December 10
- DMEPOS Competitive Bidding Surveys: Comment by December 20
- Quality Payment Program: Technical Expert Panel Nominations due December 20
- Quality Payment Program: MIPS Exception Applications due December 31
- Clinical Laboratory Fee Schedule: CY 2020 Final Payment Determinations
- Quality Payment Program: 2019 APM Incentive Payment Details
- PEPPERs for Short-term Acute Care Hospitals
- eCQM Reporting: Updated 2020 QRDA III Implementation Guide
- National Influenza Vaccination Week
- National Handwashing Awareness Week

Compliance

- Cardiac Device Credits: Medicare Billing

Claims, Pricers & Codes

- Average Sales Price Files: January 2020
- Home Health RAPs: Hold Starting January 1, 2020

Events

- Hospital Price Transparency Special Open Door Forum — December 10
- Medicare Promoting Interoperability Program 2020 Webinar — January 16

MLN Matters® Articles

- Overview of the Patient-Driven Groupings Model
- Payments and Payment Adjustments under the Patient-Driven Groupings Model
- Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2020 - Recurring File Update

Publications

- Disproportionate Share Hospital — Revised
- Federally Qualified Health Center — Revised
- Medicare Learning Network (MLN) Learning Management System (LMS) FAQs — Revised

Multimedia

- Clinical Labs Call: Audio Recording and Transcript

MLN Connects® – Special Edition for December 10, 2019

Most HICN Claims Reject – Regardless of Date of Service

Use Medicare Beneficiary Identifiers (MBIs) now to avoid claim and eligibility transaction rejects. Starting January 1, 2020, regardless of the date of service on the Medicare transaction, most Social Security Number – based Health Insurance Claim Number (HICN) Medicare transactions will reject with a few *exceptions*.

If you do not use MBIs on claims after January 1, you will get:

- Electronic claims reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber)
- Paper claims notices: Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier"

Thank you for transitioning to MBIs during the 21 month transition period, protecting your patients from identity theft.

- You are currently submitting 87% of claims with MBIs
- If your patient doesn't have their new card, give them the Get Your New Medicare Card flyer in *English* or *Spanish*
- Get MBIs through the MAC portals (*sign up*) now and after the transition period. You can also find the MBI on the remittance advice.

See the *MLN Matters Article* (PDF) for more information on getting and using MBIs.

MLN Connects® for Thursday, December 12, 2019

MLN Connects® for Thursday, December 12, 2019

View this edition as a PDF

News

- Open Payments: Review and Dispute Data by December 31
- LTCH Provider Preview Reports: Review Your Data by January 9
- IRF Provider Preview Reports: Review Your Data by January 9
- Quality Payment Program: Check Your Final 2019 MIPS Eligibility Status
- Quality Payment Program: MIPS Low-Volume Threshold Criteria for 2019
- Home Health Agencies: OASIS Considerations for PDGM Transition

Compliance

- Bill Correctly for Device Replacement Procedures

Claims, Pricers & Codes

- Payment for Outpatient Clinic Visit Services at Excepted Off-Campus Provider-Based Departments

Events

- ESRD Quality Incentive Program: CY 2020 ESRD PPS Final Rule Call — January 14

MLN Matters® Articles

- Medicare Part B Home Infusion Therapy Services with the Use of Durable Medical Equipment
- CY 2020 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
- Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List
- Update to Medicare Claims Processing Manual, Chapters 1, 23 and 35
- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements — Revised
- Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020 — Revised
- Looking for an MLN Matters Article?

Publications

- Opioid Treatment Programs (OTPs) Medicare Billing & Payment
- Hospice Comprehensive Assessment Measure

Multimedia

- Hospital Price Transparency Call: Audio Recording and Transcript

MLN Connects® – Special Edition for December 17, 2019

New Medicare Card Transition Ends in 2 Weeks: Use MBIs Now to Get Paid January 1

The 21-month Medicare Beneficiary identifier (MBI) transition period ends in two weeks. Update your patients' records and use MBIs now. Starting January 1, you must use MBIs to bill Medicare regardless of the date of service:

- We will reject claims submitted with Health Insurance Claim Numbers (HICNs) with a few *exceptions*
- We will reject all eligibility transactions submitted with HICNs

Need the MBI?

We encourage people with Medicare to carry their cards with them since we removed the Social Security Number-based number; if your patients do not bring their Medicare cards with them:

- Give them the Get Your New Medicare Card flyer in *English* (PDF) or *Spanish* (PDF).
- Use your Medicare Administrative Contractor's look-up tool. *Sign up* (PDF) for the Portal to use the tool
- Check the remittance advice. Until December 31, we return the MBI on the remittance advice for every claim with a valid and active HICN

MBI on a Patient's Card Doesn't Work?

Medicare beneficiaries, their authorized representatives, or CMS can ask to change MBIs; for example, if the number is compromised. It is possible your patient will seek care before getting a new card with the new MBI.

If you get an eligibility transaction error code (AAA 72) of "invalid member ID," your patient's MBI may have changed.

See **SPECIAL EDITION**, page 14

MLN Connects® for Thursday, December 19, 2019

MLN Connects® for Thursday, December 19, 2019

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News

- DMEPOS: Changes to Conditions of Payment Reduce Burden
- DMEPOS Competitive Bidding Surveys: Comment by December 20
- Mohs Microsurgery: Comparative Billing Report in December
- Hospice Provider Preview Reports: Review Your Data by January 15
- Hospice Providers: Volunteer for Alpha Testing of HOPE Assessment Instrument
- LTCH Compare Refresh
- IRF Compare Refresh
- 2020 Eligible Clinician Electronic Clinical Quality Measure Flows
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Compliance

- Provider Minute Video: The Importance of Proper Documentation

Claims, Pricers & Codes

- Payment for Outpatient Clinic Visit Services at Excepted Off-Campus Provider-Based Departments: Updated

Events

- Mohs Microsurgery: Comparative Billing Report Webinar — January 7
- ESRD Quality Incentive Program: CY 2020 ESRD PPS Final Rule Call — January 14
- Listening Sessions on MAC Opportunities to Enhance Provider Experience — January 15, 22, or 29

MLN Matters® Articles

- Calendar Year (CY) 2020 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for April 2020
- Update Inpatient Prospective Payment System (IPPS) Pricer and Related Claims Reprocessing
- Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS — Revised
- Medicare Part B Home Infusion Therapy Services with the Use of Durable Medical Equipment — Revised
- Looking for an MLN Matters Article?

Publications

- Hospital Quality Reporting: QRDA I Conformance Statement Resource

Multimedia

- Ambulance Services Call: Audio Recording and Transcript

SPECIAL EDITION

from page 13

- Do a historic eligibility search to get the termination date of the old MBI
- Get the new MBI from your Medicare Administrative Contractor's secure look-up tool. *Sign up* (PDF) for the Portal to use the tool

See the *MLN Matters Article* (PDF) for answers to your questions on using MBIs.

First Coast Service Options Phone Numbers

***(Note:** Specific geographic contact information is noted when phone numbers and addresses are different for providers in Florida, U.S. Virgin Islands or Puerto Rico.*

Customer service

Monday to Friday
8:00 a.m. to 4:00 p.m
888-664-4112 (FL/USVI)
877-908-8433 (Puerto Rico)
877-660-1759 (TDD-FL/USVI)
888-216-8261 (TDD-Puerto Rico)

Electronic data interchange

888-670-0940 (FL/USVI)
888-875-9779 (Puerto Rico)

Interactive Voice Response

877-602-8816

Overpayments

904-791-6029

SPOT Help Desk

FCSOSPOTHelp@fcso.com
855-416-4199

Provider websites

English
Spanish

First Coast Service Options Addresses

Claims/correspondence

Florida/ U.S. Virgin Islands

Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

Puerto Rico

First Coast Service Options Inc.
P.O. Box 45003
Jacksonville, FL 32232-5003

Medicare EDI Electronic claim filing

Direct Data Entry
P. O. Box 44071
Jacksonville, FL 32231-4071

Fraud and abuse

Complaint Processing Unit
P. O. Box 45087

FOIA requests

Provider audit/reimbursement

(relative to cost reports and audits)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268

General Inquiries

Online Form (Click here)
EDOC-CS-FLINQA@fcso.com (FL/USVI)
EDOC-CS-PRINQA@fcso.com (PR)

Local coverage determinations

Medical Policy and Procedures – 19T
P.O. Box 2078
Jacksonville, FL 32231-0048

Medicare secondary payer (MSP)

Medicare Secondary Payer
P. O. Box 44179
Jacksonville, FL 32231-4179

Hospital audits

MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

MSPRC DPP debt recovery, auto accident settlements/lawsuits, liabilities
Auto/Liability – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

Overpayment collections and debt recovery

Repayment, cost reports, receipts and acceptances, tentative settlement determinations, provider statistical and reimbursement reports, cost report settlement, TEFRA target limit and SNF routine cost limit exceptions

Provider Audit and Reimbursement
P. O. Box 45268
Jacksonville, FL 32232-5268

Credit balance reports

First Coast Service Options Inc.
P.O. Box 45011
Jacksonville, FL 32232-5011

Post-pay medical review

First Coast Service Options Inc.
P. O. Box 44159
Jacksonville, FL 32231-4159

Provider enrollment

CMS-855 Applications
P. O. Box 3409
Mechanicsburg, PA 17055-1849

Special or overnight deliveries
Provider Enrollment
2020 Technology Parkway Suite 100
Mechanicsburg, PA 17055-1849

Redetermination

Florida:
Medicare Part A Redetermination/Appeals
P. O. Box 3409
Jacksonville, FL 32232-5053

U.S. Virgin Islands:

First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

Puerto Rico

First Coast Service Options Inc.
P.O. Box 45028
Jacksonville, FL 32232-5028

Special delivery/courier services

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare carriers and intermediaries

DME regional carrier (DMERC)

DME, orthotic, prosthetic device, take-home supply, oral anti-cancer drug claims

CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Railroad Medicare

Palmetto GBA
P. O. Box 10066
Augusta, GA 30999-0001

Regional home health/hospice intermediary

Palmetto GBA
Medicare Part A
34650 US HWY 19N
Palm Harbor, FL 34684

Contact CMS

Centers for Medicare & Medicaid Services (CMS)

Centers for Medicare & Medicaid Services, Division of Financial Management and Fee for Service Operations

ROATLFM@CMS.HHS.GOV

Office of Inspector General (OIG)
Medicare fraud hotline
800-HHS-TIPS (800-447-8477)

Beneficiary customer service

1-800-MEDICARE (1-800-633-4227)

Hearing and speech impaired (TDD)
1-800-754-7820